Performance

Report

**1800 951 822**

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| Name of service: | Grace Munro Centre |
| Service address: | 2 Thunderbolts Way BUNDARRA NSW 2359 |
| Commission ID: | 0616 |
| Approved provider: | Grace Munro Aged Care Centre Ltd |
| Activity type: | Site Audit |
| Activity date: | 28 February 2023 to 2 March 2023 |
| Performance report date: | 27 April 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Grace Munro Centre (**the service**) has been prepared by G. Hope-Simpson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

* The following information has been considered in preparing the performance report:
* the assessment team’s report for the Site audit, the Site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives.
* the provider’s response to the assessment team’s report received 11 April 2023.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

* Requirement 7(3)(a): The Approved Provider ensures night shift configuration, staff number and staff mix support provision of safe and effective care; that staff are appropriately qualified and hold necessary registrations for their roles and that unplanned and planned leave are backfilled with appropriately qualified and registered staff. The Approved Provider ensures all improvements outlined in the service’s plans for continuous improvement are implemented.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and representatives reported staff treat them well, are respectful and consider consumers’ culture in care provided. Care planning documentation reflected each consumers’ cultural background, spiritual preferences, family relationships, activities of interest, and individual preferences. Staff demonstrated a sound understanding of consumers’ individual preferences and how they provide care that is dignified, respectful and culturally appropriate.

Consumers and representatives said the service delivers care that meets the needs and preferences of consumers. Staff knew how to adapt care and services to assist consumers to maintain their cultural preferences and choices. The service has arrangements in place for monthly multi-denomination services to be held at the service to support consumers’ cultural and religious needs.

Consumers and representatives said the service supports consumer choices and preferences for care and services including to maintain relationships and stay connected. Staff explained how they support consumers to make decisions about care and services such as preferred time of waking, showering or having meals. Staff said changes in care are communicated to clinical management and at handover.

Consumers and representatives said consumers are supported by staff to take risks and live the best life they can. Staff described areas in which consumers who wanted to take risks were supported to understand the benefits and possible harm when making decisions about taking risk and finding solutions to reduce risk where possible. Risk assessments including allied health input, were reflected in care planning documentation.

Consumers and representatives said they get information in a way they can understand and were aware of scheduled services and activities coming up. Staff described communication strategies including recognising non-verbal cues for consumers with cognitive deficits, creating large daily activity calendar for visual impairment and writing things down for hearing impaired consumers. The service’s menu and activity program were easily accessible, copies were provided to consumers and detailed on the noticeboards.

Consumers and representatives said the service and staff respected their privacy and personal space particularly when having visitors; they felt their personal information is kept confidential. Staff described privacy requirements for consumers such as not speaking about consumers in public areas, knocking on doors, closing doors during care delivery, and respecting consumers preferred waking time. Staff were observed using their individual login and password to access the electronic care management system.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Following a Site Audit from 18 to 19 May 2021, the service was found non-compliant in Requirements 2(3)(a), 2(3)(b), 2(3)(c). Evidence in the site audit report dated 28 February 2023 to 2 March 2023 supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with these Requirements.

Requirement 2(3)(a)

Consumers and representative said consumer care is well planned, staff take time to understand how to support consumers, including identifying risks and management strategies. Staff described assessment and care planning processes, how risks are identified for consumers and were familiar with consumers who had chosen to take risks. Care planning documentation reflected risks had been identified for consumers and with input from allied health providers.

Requirement 2(3)(b)

The advanced care register evidenced that directives were in place for consumers who wished to have one in place and care planning documentation reflected consumers and representatives are provided the opportunity to discuss advanced care planning and end of life care. Staff identified consumers on a palliative pathway and described completing daily assessments and monitoring pain to ensure consumers were comfortable. The service has strategies, policies and procedures to guide staff when delivering end-of-life care.

Requirement 2(3)(c)

Consumers confirmed they have regular care plan reviews and other providers are involved in care planning such as their medical officer and dieticians. Care planning documentation evidenced integrated and coordinated assessment and planning involving all relevant organisations, individuals, and service providers to meet the consumer’s needs, goals, and preferences. Management described how the policy guides care plan reviews upon admission, following an incident such as after falls, hospital admissions, or changes in pain.

Regarding the remaining compliant requirements of Quality Standard 2:

Consumers and representatives said the service regularly communicates with them about consumer care, they are offered a copy of their care plan, staff explain their care plan to them, and it meets the consumers’ needs, goals, and preferences. Staff described the care planning process including offering a copy to the consumer and representative which can be emailed. The service’s policy supports effective communication of the outcomes of assessment and planning to those involved with care.

Consumers and representatives said they are regularly contacted when circumstances change, when incidents occur or when consumer’s needs, goals or preferences change. Care planning documentation evidenced routine 3 monthly reviews, when changes in consumer needs occurred or for general health deterioration. Staff said when incidents occur or concerns are raised, they evaluate the consumer for injury and report it to management for further instructions and assessment.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Following a Site Audit from 18 to 19 May 2021, the service was found non-compliant in Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(f) and 3(3)(g). Evidence in the site audit report dated 28 February 2023 to 2 March 2023 supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with these Requirements.

Requirement 3(3)(a)

Consumers and representatives said they are satisfied with care and services delivered which is tailored to consumer needs and preferences. Care planning documentation demonstrated consumers are receiving care in line with their assessed care needs, which optimises their well-being. Management described their roles and responsibilities for incident reporting and clinical data analysis to identify trends and clinical policies are in place to guide staff best practice.

Requirement 3(3)(b)

Staff described care plans for consumers with high risk such as for those with pressure area risk, complex care, falls and changed behaviours. Staff were familiar with consumers subject to restrictive practices, care planning documentation evidenced behaviour supports plans were in place and risks closely monitored and reviewed regularly. Improvements in relation to medication administration, storage and handling of Schedule 8 medications, falls risk assessment and behaviour had been implemented. The service has clinical policies specifically directed to high risk available to guide staff on best practice for all clinical areas.

Requirement 3(3)(d)

Consumers and representatives said they are satisfied with the delivery of care, including the recognition of deterioration or changes in their condition. Care planning documentation, progress notes, and charting demonstrated deterioration in a consumer’s health, capacity, and function are recognised and responded to. Staff described recent examples when they respond to changes such as for the consumer exhibiting signs of deterioration, a urinalysis was taken, and dehydration was identified and managed appropriately. Improvements in access to the medical officer and in management of behaviour had been implemented.

Requirement 3(3)(f)

Staff described the newly implemented process for referring consumers to other health professionals and allied health services. Progress notes in care planning documentation reflected timely input from other providers such as the consumer’s doctor, podiatrists, physiotherapists, and dietitian. The service provided a list of referral agencies demonstrating links with a range of providers including clinical, medical, social, and pathology services.

Requirement 3(3)(g)

Consumers and representatives said the service is clean, staff practice good infection control, and they receive education by the infection and prevention control lead. Staff were observed to be wearing appropriate personal protective equipment, practicing hand hygiene, maintaining social distancing, and sanitising equipment. Cleaning staff were aware of touch point cleaning processes and were observed doing touch point cleaning. Since the previous site audit, the service had updated its Outbreak Management Plan

Regarding the remaining compliant requirements of Quality Standard 3:

Representatives said they had completed advance care directives for consumers, and this was reviewed regularly. Care planning and assessment documentation for palliating consumers demonstrated their advance care and end of life preferences were documented and being delivered. Signed advance care directives were in place for each consumer where they had chosen to have one.

Consumers and representatives said the service coordinates their personal and clinical care well, consumer information is documented, communicated appropriately within the service and shared with others when care is shared. Staff explained how changes in consumers’ care and services are documented and communicated, including at handover, updating care plans and progress notes, and at staff meetings.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers said they are satisfied with the range of activities and services provided to them. Staff described the lifestyle care planning and review process and how they select activities based on consumer’s individual needs and group preferences. A monthly activities calendar was observed displayed in each consumer’s room and in common areas including reception. Lifestyle assessments were used to determine consumers’ lifestyle needs and preferences.

Consumers expressed how they could talk to a lifestyle staff member if they needed. Staff described how they escalate consumers’ emotional needs to a lifestyle staff member and how the lifestyle staff member follows up. Care planning documentation included consumers’ emotional, spiritual, and psychological needs and preferences and strategies to support consumers.

Consumers described how staff support them with their life choices, they are free to attend activities with their family and friends as desired. Consumers were observed interacting with their loved ones at the service and having social community outings with family and representatives. Care planning documentation identified what is important to consumers and included strategies to support these choices.

Consumers described how staff know their needs and preferences. Staff described various ways consumers information is shared such as via the electronic care management system and at handovers. Care planning documentation showed effective communication where care is shared for example, by physiotherapists, podiatrists, and speech pathologists.

Care planning documentation demonstrated how the service collaborates with other individuals, organisations, and service providers to support the diverse needs of consumers. Staff identified how they refer consumers to individuals, organisations, and providers that consumers require additional care and supports from and how consent is gained.

Consumers said food at the service is of high quality and quantity. Consumers and staff were very proud that the service had recently been ranked as one of the best in the state for the quality and quantity of food provided to consumers. The service involves consumers in the development of the menu and encourages feedback on the quality of the food provided.

Consumers and representatives said they have access to equipment, including shower chairs and manual handling equipment, to assist them in their daily living activities, as well as resources and equipment for leisure and lifestyle activities. Staff said they have access to equipment when they need it and described how equipment is kept safe, clean and well maintained. Cleaning and maintenance schedules were up to date and checked daily.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Following a Site Audit from 18 to 19 May 2021, the service was found non-compliant in Requirement 5(3)(b). Evidence in the site audit report dated 28 February 2023 to 2 March 2023 supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with this Requirement.

Requirement 5(3)(b)

Consumers were satisfied the service was clean, safe, and well maintained and said their rooms were cleaned regularly and maintenance issues were dealt with quickly. Communal areas and outdoor spaces were observed to be clean; tidy and free of hazards, and consumers were observed moving freely inside and outdoors, including leaving the premises through the main doors. Consumers and staff said sufficient equipment is available, maintenance is managed effectively, and they knew what to do if they identified a hazard or safety issue.

Regarding the remaining compliant requirements of Quality Standard 5:

The service environment was observed to be calm, friendly and welcoming, with communal and private areas for consumers and their visitors to use. Sufficient light was observed throughout the service, signs were printed in large lettering, and handrails were in all corridors to assist consumers to find their way and move around easily. Consumers said they were comfortable and felt a sense of belonging and independence.

Furniture in communal areas and consumers rooms was observed to be well maintained, safe and clean and consumers were observed walking freely in the service. Staff explained how shared equipment used for moving and handling consumers, such as hoists, slings, and shower chairs, were cleaned and knew how to tag faulty equipment as ‘unsafe for use’ and log a maintenance request.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Following a Site Audit from 18 to 19 May 2021, the service was found non-compliant in Requirement 6(3)(c) and 6(3)(d). Evidence in the site audit report dated 28 February 2023 to 2 March 2023 supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with these Requirements.

Requirement 6(3)(c)

Consumers and representatives expressed satisfaction with the complaints process and described a response from management that aligned with the principles of open disclosure. The service had policies and procedures to guide the complaints management and open disclosure process and staff demonstrated awareness of these procedures. The complaints register demonstrated that complaints and feedback are managed in line with policy and procedure.

Requirement 6(3)(d)

Consumers and representatives said their complaints or feedback had resulted in improvements to care and services. The service demonstrated systems used to record and analyse complaints to identify trends and inform improvements. Minutes of meetings including consumer meetings and staff meetings showed that feedback and complaints are discussed to ensure trends are understood across the service and complaints are used to inform improvements. The continuous improvement plans included items in response to complaints and feedback.

Regarding the remaining compliant requirements of Quality Standard 6:

Consumers and representatives said they were comfortable to provide feedback and make complaints. Staff and management spoke of encouraging and supporting consumers and representatives to do so and management spoke of how they encourage staff. Feedback forms, brochures, and posters for internal and external complaints services, were readily available and accessible to consumers visitors, contractors, and staff with a feedback box located in the main corridor of the service.

Consumers and representatives said they are aware of other avenues for raising and resolving complaints such as attending consumer meetings or contacting government services. Staff demonstrated an understanding of advocacy services available for consumers and described strategies they would use to assist consumers with communication barriers.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

In the site audit report the Assessment Team recommended Requirement 7(3)(a) (workforce planning, sufficiency and mix) was not met. Relevant summarised evidence from the site audit report, as well as the Approved Provider’s response, is outlined below.

The Assessment Team considered the service was unable to demonstrate compliance with this Requirement, citing deficits related to a shortage of key staff, including clinical management and/or an additional registered nurse, during periods of unplanned leave. Additionally, one consumer said they felt there should be one more registered nurse because the workload was too much for current management. Most consumers and representatives, however, said they do not have an issue when it comes to their care and service needs being met as there is always a staff member available when needed.

Interviewed staff reflected on sleepover shifts, with all stating they do not sleep during those times, for fear they may not hear a named consumer calling out. Staff said although service management was aware staff stay awake during the sleepover shift, management did not consider it was necessary to change the shift to an ‘awake’ one. The staffing of the night shift had not been reviewed in line with changing consumer need. Lastly, the Assessment Team found the service had no policies or procedures outlining the qualifications and training required for staff managing the service in the absence of the service manager, who was also the RN. It was found that staff engaged to run the service in the absence of the service manager/RN were employed as a personal care worker and care staff, respectively.

The Approved Provider’s written response of 11 April 2023 disagreed with many of the site audit report findings. The response clarified perceived inaccuracies in the report and outlined that all periods of unplanned absences referred to in the site audit report had been covered and there were no unplanned absences where registered nurse services were not available, mostly through contracted registered nurses and a COVID-19 team who were onsite during an outbreak. However, documentary evidence provided with the response did not demonstrate full coverage of all the unplanned absence periods outlined.

The Approved Provider did, however, submit the service’s plan for continuous improvement (PCI) identifying improvements to workforce planning such as reviewing staffing requirements for the overnight shift. The PCI also contained an undertaking to review Position Descriptions for the overnight shift, to recruit additional Registered Nurses to ensure adequate replacement or backfilling of key staff and to review policies, guidance resources and the roles and responsibilities of registered staff and management. At the time of writing this Performance Report, the response noted the service had recruited 2 additional RNs and the review of relevant policies, guidance resources and position descriptions for management and nursing staff had commenced.

I have considered the evidence brought forward by the Assessment Team and the Approved Provider in its’ response. I consider the Site Audit Report demonstrated there were deficits in workforce planning leading up to the time of site audit, and the Approved Provider’s response failed to demonstrate coverage of all unplanned leave periods throughout 2022 and early 2023. I acknowledge there was no demonstrated impact to consumers as a result of these issues, and that the service has taken appropriate steps since the site audit to address deficits in workforce planning. However, the steps outlined in the PCI will require time to become embedded, and most improvement actions have been commenced, or are listed as ‘ongoing’ rather than completed. Based on this, I consider the service requires time to demonstrate effective improvement actions have been implemented, evaluated and sustained. On this basis, I find the service does not comply with Requirement 7(3)(a).

Regarding the remaining compliant requirements of Quality Standard 7:

Consumers said that staff are kind and caring and that they respect their identity, culture, heritage, and diversity. Staff could demonstrate how they provide care that is respectful to identity, culture, and diversity. Interactions were observed to be caring and respectful, with staff taking time to interact with consumers. Care planning documents demonstrate that the consumer’s story, needs and preferences are known. There is a recruitment process that ensures staff are chosen in line with the values of the organisation. Staff receive training and support to deliver care in accordance with the organisations’ Choice Dignity and Diversity policy and procedure.

Staff receive comprehensive and ongoing training and supervision. Consumers and representatives said staff know what they are doing, and they are well trained. The service manager described the organisation’s training program and relevant processes for identifying staff training needs and described how this informs the training schedule and ensures competency. Staff receive training in Quality Standards as part of the orientation provided by the service. Staff also receive informal on the job training during handovers and staff meetings.

Consumers and representatives said staff know what they are doing and were adequately trained; staff confirmed they receive ongoing training. Training documentation evidenced staff training is provided on recruitment and on an ongoing basis to ensure staff have sufficient knowledge to deliver the outcomes required by these Standards. Training records demonstrated high completion rates of required staff training.

The service has a process to regularly assess, monitor, and review the performance of staff, including annual performance appraisals. Staff demonstrated awareness of the service’s performance appraisal process including discussions of their performance and areas where they would like to develop their skills and knowledge. The service has policies and procedures related to assessment, monitoring, and review of staff performance.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

In the site audit report the Assessment Team recommended Requirement 8(3)(b) was not met. The Assessment Team also recommended Requirement 8(3)(c) was not met, noting that the service was previously found to be non-compliant with this Requirement following a Site Audit from 18 to 19 May 2021.

After considering evidence contained within the Site Audit Report as well as the Approved Provider’s response, I have come to a different view regarding Requirements 8(3)(b) and 8(3)(c). I have provided evidence and reasoning for my decisions below.

Requirement 8(3)(b)

The Site Audit report brought forward concerns regarding the role and accountability of the governing body in promoting a culture of safe, inclusive and quality care and service. These related to the Board meeting regularly in accordance with organisational procedures and ensuring two-way communication between the governing body and the service. Other evidence brought forward in the site audit report was not relevant and has not been considered here.

In the Approved Provider’s written response of 11 April 2023, the Provider disagreed with deficits brought forward in the Site Audit Report, advising that due to unforeseen circumstances including COVID-19 impacts and key staff member absences, formal Board meetings did not always occur as scheduled during 2022, however, in the absence of formal Director’s meetings, a minimum twice weekly telephone contact was made with Directors, although these were not recorded. In addition, the Approved Provider advised that reports generally were received from management at the service and feedback from the Board to the service and staff is procedurally via management via consumer and staff meetings. However, due to several unplanned absences of key staff during 2022, this level of communication had not always occurred. The Approved Provider has undertaken to improve communication through continuous improvement efforts and submitted a revised continuous improvement plan dated April 2023, detailing action items to address deficits including ensuring management communication to staff and consumers following outcomes from Directors Meetings, recording of such in consumer and staff meeting minutes and reviewing relevant policies and procedures.

I have considered information in the site audit report and the approved provider’s response. I was persuaded by the response and accept while formal Board meetings may not have consistently occurred, there was regular communication between the service and the board. Given the size and remote location of the service, this level of contact with the governing body was appropriate in the circumstances. I am also satisfied the organisation has taken adequate steps, by revising the continuous improvement plan, to document contact between the board outside of formal meetings. I have also considered that the application of site audit methodology may have influenced some findings in the Site Audit Report.

Lastly, I have had regard to information contained within the Providers’ response outlining the Board’s decision to participate in the Department of Health-funded Service Development Assistance Panel, for a review of all organisational policies and procedures. I consider this demonstrates willingness and commitment by the governing body to promote a culture of safe, inclusive and quality care and services. Overall, I am persuaded by the Approved Provider’s response and on balance, find the examples brought forward in the Site Audit Report do not demonstrate non-compliance with Requirement 8(3)(b).

Requirement 8(3)(c)

Following a Site Audit from 18 to 19 May 2021, the service was found non-compliant in Requirement 8(3)(c), with deficiencies related to the service’s information management systems and appropriate storage and labelling of personnel files, consumers’ records and poor documentation practices. Additionally, the service did not have in place a plan for continuous improvement to improve the quality of care and services. Feedback and complaints were not tracked or logged centrally according to the service’s policy and procedure.

Evidence in the site audit report dated 28 February 2023 to 2 March 2023 was used to support the Assessment Team’s recommendation that the service continues to be non-compliant with this Requirement.

The Site Audit Report identified that some previous deficits had been addressed through improvements delivered by the service, however, ongoing and new deficits were brought forward in relation to organisational systems for information, continuous improvement; financial governance; workforce governance; regulatory compliance; feedback and complaints. Relevant deficits identified included poor communication between the Board and service management, the continuous improvement plan being out of date, equipment purchasing procedures, staffing issues as outlined in Standard 7, policies and procedures not being current and gaps in feedback and complaints processes. Concerns that staff had not had sufficient training in use of the electronic care management system was also noted. Other evidence was not relevant and has not been considered.

In the Approved Provider’s written response of 11 April 2023, the Provider disagreed with these findings and provided an explanation and supporting evidence to show that the electronic version of the continuous improvement plan had been current at the time of the site audit and also outlined several examples of continuous improvement which had been implemented prior to the site audit. In relation to regulatory compliance, the response noted all policies and procedures were up to date and due for review from June 2023, following participation in the Service Development Assistance Panel program, as previously discussed. Regarding feedback and complaints systems, the response gave a clear account of the processes in place, sufficient to refute evidence outlined in the site audit report. I am satisfied deficiencies relating to poor communication were sufficiently addressed under Requirement 8(3)(b) and workforce governance under Requirement 7(3)(a) where they were more relevant. The Approved Provider submitted evidence to show identified improvements across organisational systems have been included in the continuous improvement plan, including additional training in use of the electronic care management system.

In coming to a decision, I have considered available evidence on balance, and find the response and additional evidence provided by the Approved Provider demonstrates that the service has generally effective organisational systems in place including for information, continuous improvement; financial governance; regulatory compliance and feedback and complaints. While I accept there have been deficits in workforce planning, on balance, the response contained sufficient evidence to demonstrate steps taken since site audit to address workforce governance issues, which were outlined previously in Requirement 7 (3)(a). I have also had regard to the application of site audit methodology and consider that sampling methods used during the audit may have influenced the Assessment Team’s findings. Lastly, I have had regard to the Assessment Team’s finding that where paper-based records had been used instead of the electronic care management system, no detrimental impact to consumers was identified. Based on these reasons, I therefore find the service is compliant with Requirement 8(3)(c).

Regarding the remaining compliant requirements of Quality Standard 8; following a Site Audit from 18 to 19 May 2021, the service was found non-compliant in Requirement 8(3)(a) and 8(3)(d). Evidence in the site audit report dated 28 February 2023 to 2 March 2023 supports the service has implemented improvements to address areas of non-compliance and now demonstrates compliance with these Requirements.

Requirement 8(3)(a)

Consumers and representatives said they were involved in design of their care and services. Staff detailed how consumers are engaged to partner in the development, delivery and evaluation of the care and services such as consumer surveys, feedback mechanisms and consumer meetings. Management described how data received from feedback forms, surveys and meetings is captured into an integrated quality improvement system for analysis to inform improvements.

Requirement 8(3)(d)

The service was observed to have risk management systems, policies and procedures implemented to monitor and assess the high impact or high prevalence risks associated with the care of consumers. Staff said risks are reported, escalated, and reviewed by management and reported to the governing body through the clinical report prior to the governing body meetings. Management described how incidents are analysed, used to identify risks to consumers and inform improvement actions. Deficits in information management, particularly in relation to charting of wound care, bowel management and progress notes was identified, however no impact to consumers was identified.

Requirement 8(3)(e)

The service has a documented clinical governance framework in place; management and staff said they apply the principles of the framework when providing clinical care such as minimising restrictive practices, implementing antimicrobial stewardship strategies, and providing open disclosure to consumers and representatives when things go wrong. Documented policies include clinical governance framework, infection control management, antimicrobial stewardship, restrictive practices, diversity and cultural inclusion, and open disclosure.

1. The preparation of the performance report is in accordance with Section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)